Appendix B

Indian Health Case Study

Appendix B: Case Study Using Nutrition Practice Guidelines: **Initial Visit**

IHS Form: PCC Ambulatory Encounter Record

Date: 09/18/05

Start time: 1:00 pm

End time: 2:00 pm

Clinic: 67

Appointment _X_ Walk-in____

Primary provider affiliation: 1

Discipline: 29

Initials/code: cb

Referral by treating physician:

Dr. T. Bear, MD, on 08/29/05 to registered dietitian for type 2 diabetes management, MNT, and weight loss.

Presentation:

G.C. is a 53-year-old Pueblo woman diagnosed with type 2 diabetes two years ago. She has three grown children who live with her. G.C. is self-employed. She gets up early every day to make the trip into Santa Fe to sell her Pueblo jewelry at the portal on the plaza. She spends long hours sitting and most of her meals are eaten out of the home. Her mother died last year from diabetes complications, and she has a younger sister with diabetes who recently started dialysis. She neither smokes nor drinks alcohol.

G.C. usually eats a mid-morning meal of two fried eggs, fried potatoes with corned beef hash, a large tortilla, 16 ounces of orange juice, and two cups coffee with milk. She purchases this meal at the local restaurant near the plaza in Santa Fe. Her favorite snacks throughout the day include popcorn, candy bars, soda pop, sunflower seeds, and pinon pine nuts. She joins her family at 8:00 p.m. for an evening meal of a bowl of chili stew with beans and meat (often deer or elk), two slices of oven bread, and coffee with milk.

G.C. s physician has suggested she start walking to manage her blood sugars and lose weight, and has referred her to see the RD for MNT at the clinic. She started walking 10–15 minutes /day two days ago, but has little energy and gets tired easily.
G.C. was monitoring her blood glucose until a few weeks ago. She has recently stopped checking her blood glucose because the values are over 200, she has run out

of blood glucose strips, and she is discouraged and scared. She recalls that blood glucose values were often above 200. She takes her medications most days (about five out of seven days), but sometimes forgets.

Nutrition-focused assessment:

Labs: 08/26/05

A1C: 9.5% (high; goal ≤ 6.5%)

Lipids: LDL-C = 110 mg/dl (high; goal ≤ 70 mg/dl)

Total Cholesterol = 210 mg/dl (high; goal ≤ 200 mg/dl)

HDL-C = 40 mg/dl (low; goal > 50 mg/dl)

Triglycerides = 200 mg/dl (high; goal ≤ 150 mg/dl)

Microalbuminuria: 14 mcg (within goal range of ≤ 20 mcg)

Blood pressure:

136/88 today

140/90 at previous visit (high; goal ≤ 130/80)

Weight history:

Current weight = 242.8 pounds

Current height = 66 inches

BMI = 39.2

Highest weight ever. Several attempts at food restriction and popular diets, with modest weight loss and weight re-gain after six months.

Tobacco and alcohol use:

No tobacco use.

No alcohol use.

Medications:

Metformin: 500 mg twice a day

Glipizide: 10 mg twice a day

Aspirin: 81 mg per day

Lisinopril: 5 mg per day

(Diabetes medication prescription stable for past year.)

Eating pattern:

Two meals plus two to three snacks per day.

AM meal: Two fried eggs, one cup potatoes with corned beef hash, one large tortilla, 16 ounces orange juice, and two cups of coffee with milk all purchased at a downtown Santa Fe restaurant.

Afternoon snacks: One to two regular sodas, one candy bar, handful of pinon pine nuts eaten on the plaza.

PM meal: Usually traditional Pueblo foods; one bowl green chili with beans and meat (often deer), two slices oven bread, and two cups coffee with milk eaten at home with family.

Physical activity:

Sedentary

Two days ago started to walk 10 15 minutes, experiencing fatigue.

Short-term goals negotiated:

1. ≤ 50% of blood glucose in FPG range of 90 130 and two hours after meal; < 160 to be achieved through consistent carbohydrate intake; budget of 120 g/day; medications; and daily short walks.
2. Weight loss of 1 2 pounds per week.

Long-term goals negotiated:

1. A1C ≤ 6.5%.
2. Weight loss of 10 14 pounds within six months, and weight loss maintenance for improved insulin response.
3. Blood pressure control ≤ 130/80.
4. LDL-C ≤ 70 mg/dl.

Intervention:

1. Address emotional issues related to diabetes and weight. G.C. shares her biggest fear is the possibility of dialysis like her sister. "I don't want that to happen to me. I want to get my energy back, and not have problems like my sister and losing my mom." G.C. is motivated to manage her blood glucose. Provide support and encouragement for the positive steps she is taking to take charge of her diabetes.

2. Ask G.C. to identify foods that impact her diabetes control. She identifies sweets. Using food replicas and meal plan handout, identify the foods with carbohydrates, and explain concept of carbohydrate budget. Offer choices to G.C. to reduce carbohydrates: (a) reduce liquid sugar beverages such as soda pop and orange juice to ≤ ½ cup/day; (b) increase intake of non-starchy vegetables to ≥ 1 cup/day; and (c) reduce by half the intake of bread portions at meals.
3. Discuss benefits of SMBG and short-term goals of blood glucose checks.
4. Encourage and reinforce short daily walks for increased physical activity (essential for weight loss maintenance, increased HDL, improved mood, and reducing blood glucose).
5. Encouragement given for medication use. Discuss medication prescription, and possible need for additional medication with meal plan to reduce A1C to long-term goal.

Plan and evaluation:

1. MNT: G.C. agrees to replace regular sodas with diet sodas and water, and follow two main meals, two snacks meal pattern with carbohydrate budget of 45:15:15:45 g.
2. Physical activity: G.C. agrees to continue walks; short walks of 5–10 minutes as breaks around the Santa Fe plaza.
3. SMBG: G.C. agrees to resume blood glucose checks; once a day to begin, fasting. "I will check my blood sugar first thing in the morning to begin with, and bring the record book back for the next visit." Issue logbook, and reinforce blood glucose goals. Referral given to the pharmacy (or diabetes program) to receive blood glucose supplies and pillbox.
4. Medications: Recommend use of pillbox, stored in kitchen near meal preparation . "I'll put the medicines where I'll remember to take them every day." Recommend to referring physician to intensify pharmacotherapy an increase in diabetes medication metformin (currently at half maximum dose; no change has been made in past 12 months) to reduce fasting blood glucose. MNT and physical activity can reduce A1C by 1 2 points within six weeks (from 9.5 to 8.5 or 7.5; short of goal of ≤ 6.5).
5. Follow-up: Schedule follow-up MNT and diabetes management for four weeks to evaluate goals.

Purpose of visit:

97802 MNT Medical Nutrition Therapy, Initial

Diabetes type 2 uncontrolled

Extreme obesity

Patient education:

DM – MNT–G –10 min – cb (Discuss one or more ways diabetes has affected her life and the lives of family members)

DM – MNT– F– 10 min – cb (Describe the effect of food on diabetes and how timing and consistency of food can help people with diabetes target their blood sugar goals)

DM–E X– G – 5 min – cb (State personal plan for physical activity)

DM–M – G – 5 min – cb (State the importance of taking medicines as prescribed)

DM–HM – G–15 min – cb – GS (Set goal for time of check and desired range)

(**Note from writing team**: To determine the MNT billing units, the billing staff will use the start time and end time of the patient face-to-face visit. In this case study, the start time is 1:00 p.m., and the end time is 2:00 p.m., for a total of 60 minutes [see page 38].)

Revisit:

4 weeks

Purpose:

Evaluate goals, behavior changes

Instructions to patient:

1. Reduce intake of sugary drinks. Drink diet sodas, tea, coffee, water without sugar. Reduce fruit juice intake to ½ cup/meal.
2. Increase intake of non-starchy vegetables that she likes, such as spinach and green chili.
3. Reduce bread intake from 3–4 servings to one serving per meal.
4. Continue walks around the plaza with two short walks (5–10 minutes)/day. Increase if you have the energy, such as 10–15 minutes/day.
5. Use pillbox, and take all medications as prescribed.
6. Begin to monitor fasting blood sugar daily, write in logbook, or return with meter (check memory feature).
7. Use spiritual means to cope with stresses of life and diabetes. Patient acknowledges prayer as a helpful mean.

Signature of Primary Provider: ***Cecilia Butler, RD, CDE***

Cecilia Butler, RD, CDE

Appendix B: Case Study Using Nutrition Practice Guidelines: **PCC Form for Initial Visit**

IHS-903 (10/96) P.L. 94-581 N.A.

PCC AMBULATORY ENCOUNTER RECORD

Date 9/18/05
Arrival Time 1:00 2:00 AM PM
Clinic 67
Appt ✓ Walk-in

PROBLEM LIST UPDATE (Enter Problem Numbers From Health Summary)
Remove | Move to Inactive | Move to Active

AFFIL. | DR. | INITIALS/CODE
PROVIDERS
PRIMARY PROVIDER 1 | 2 9 | CB

Referral Dr. Bean 8/9/05

TEMP PULSE RESP BP 138/88

CHIEF COMPLAINT: Initial visit: Low energy, tired + needs to lose weight
SUBJECTIVE/OBJECTIVE: 5) Stopped checking blood glucose few wks. ago (usually >200). Forgets to take meds 2 day/wk. Just started walking 10-15 mins. 2 days ago. Self-employed (Jewelry). Family Hx of DM (mother died, sister started dialysis). Most meals restaurants and suppers usually at home & extended family. 24 hr recall.
Breakfast: 2 fried eggs, fried potatoes, corn bread, toast, large tortilla, 16 oz juice, 2 c coffee & milk
Lunch (skips) will snack popcorn, candy bar, soda pop, flavored seeds, pine nuts
Supper bowl of chile, meat, beans, bread

WT 242.8 ☐ CH ☐ KG ☒ LB/OZ
HT. 66 ☐ CM ☒ IN
HEAD ☐ CM ☐ IN
VISION - UNCORRECTED R L
VISION - CORRECTED R L

0) BMI 39.2 (labs 8/26/05)
meds: metformin 1000mg bid, Glipizide 20 mg bid — A1c 9.5 chol 210
Education: Exercise, carb load/day, meds., goals wt loss, SMBG — LDL 110 Trig 200 HDL 40 microalb 14
A) Sedentary but motivated to start exercise aid in highest

Injury? ☐ Yes ☐ No If yes, Date: ☐ ETOH Related ☐ Employ. Rel.
Cause: Energy level and wt. loss & improved Plan: glycemic control.

(For additional Documentation, Use IHS 49-3 Continuation Sheet)

OTHER TESTS/PROCEDURES/ORDERED: Proactive in good setting; better understanding of Lowfits for SMBG, taking meds, diet and lifestyle changes. Needs follow up.

PROBLEM LIST A/M/C	#	PURPOSE OF VISIT (PRINT ONLY IN THIS SECTION; DO NOT ABBREVIATE)	Health Factors
		Diabetes type 2 uncontrolled	(-) tobacco
		Extreme obesity	(-) alcohol
		Medical Nutrition Therapy 97802 (60 min)	

REPRODUCTIVE FACTORS: G P LC SA TA LNP | FP METHOD | DATE BEGUN
PROBLEM LIST NOTES STORE NOTE FOR PROB. # | REMOVE NOTE #
STORE NOTE FOR PROB. #

MEDICATIONS | MEDICATIONS / TREATMENTS / PROCEDURES / PATIENT EDUCATION

DM-MNT-G-10 min-cb
DM-MNT-F-10 min-cb
DM-EX-G-5 min-cb
DM-HS-G-5 min-cb
DM-Hm-G-15 min-cb-GS

HR # | SSN # | REVISIT/REFERRAL TO: 4 weeks DATE TIME
NAME G.C. | PURPOSE: Evaluate Goals
B.DATE SEX | TRIBE | INSTRUCTIONS TO PATIENT: Plan ☐ SIGN RELEASE RECORDS
RESIDENCE
FACILITY | DATE

1) Carb budget 45:15:15:45g bid
2) Exercise 5-10 min/d
3) SMBG fasting - goal 90-130
4) Use Pillbox for meds.

PROVIDER SIGNATURE: Carla Bentley RD, CDE

ORDER | INITIALS
✓ HCT
UA
HGB
RBS/FBS/2
GSC
Urine culture
Throat culture
Stool culture
STS
GC
Pelvic
Breast
Mammogram
Rectal
Chest X-ray
EKG
Smear
Hep B #
Hep A #
OPV #
DTP #
DT aP #
DT
Td
MMR #
Varicella
Influenza
Hib TITANUS ADULT #
Pediatric HIB #
Pneumo Vac
PPD mm
✓ Type of Decision Making
Straightforward
Low Complexity
Moderate Complexity
High Complexity

Appendix B: Case Study Using Nutrition Practice Guidelines: **Follow-up Visit**

IHS Form: PCC Ambulatory Encounter Record

Date: 10/24/05

Start time: 9:00 am

End time: 9:45 am

Clinic: 67

Appointment _X_ Walk-in____

Primary provider affiliation: 1

Discipline: 29

Initials/code: cb

Referral by treating physician:

Initial referral by treating physician Dr. T. Bear, MD, on 08/29/05 to registered dietitian for type 2 diabetes management, MNT, and weight loss. Four-week follow-up MNT visit.

Presentation:

G.C. is a 53-year-old Pueblo woman diagnosed with type 2 diabetes two years ago. She is returning today for her follow-up MNT appointment. She has been checking fasting morning blood sugars four to five days per week, and returns with her logbook. She is pleased with the values. She is taking her medication daily, and explains, "It helps to have the pillbox on the kitchen table". G.C. is walking every other day around the portal for 15–20 minutes when jewelry sales business is slow. She is feeling more energetic and sleeping better because she doesn t have to get up at night to go to the bathroom.

She has made changes in her afternoon snacks. She is packing an orange and apple for a snack, along with some baby carrots and pinon nuts. She is drinking only water for snack, and coffee (without sugar) for meals. G.C. continues to have her midmorning breakfast at the restaurant, and is asking for her usual meal, eating only half of the tortilla (saving half for the mid-afternoon snack), substituting scrambled eggs for fried eggs, and eating half of the corn beef hash with potatoes. It has been hard during the evening because the family eats together. She doesn t want the family to stop eating all the foods they enjoy because of her.

(Appendix B: Case Study Using Nutrition Practice Guidelines: **Follow-up Visit** – continued)

Nutrition-focused assessment:

Labs: 08/26/05

A1C: 9.5% (high; goal ≤ 6.5%); A1C due 11/26/05

Lipids: LDL-C = 110 mg/dl (high; goal ≤ 70 mg/dl)

Total Cholesterol = 210 mg/dl (high; goal ≤ 200 mg/dl)

HDL-C = 40 mg/dl (low; goal > 50 mg/dl)

Triglycerides = 200 mg/dl (high; goal ≤ 150 mg/dl)

Lipids due 02/06

Microalbuminuria: 14 mcg (within goal range of ≤ 20 mcg)

Blood pressure:

130/85 today; 136/88 at previous visit (improved; goal ≤ 130/80)

140/90 at previous visit (high; goal ≤ 130/80)

Weight history:

Current weight = 240.0 pounds

BMI = 38.7

Weight loss of 2.8 pounds in four weeks.

Tobacco and alcohol use:

No tobacco use.

No alcohol use.

Medications:

Metformin: 500 mg twice a day
(Referring physician prescribed [10/23/05] increase in metformin [total 1,500 mg] from 500 to 1,000 mg at evening meal; remaining medications stable.)

Glipizide: 10 mg twice a day

Aspirin: 81 mg per day

Lisinopril: 5 mg per day

Eating pattern:

Two meals plus two to three snacks per day.

AM meal: Two scrambled eggs, ½ cup potatoes with corned beef hash, ½ large tortilla, and two cups of coffee with milk–all purchased at a downtown Santa Fe restaurant.

Afternoon snacks: Brought from home: one diet soda, one bottled water, one apple, one orange or handful of pinon pine nuts eaten on the plaza.

PM meal: One bowl green chili with beans (about ½ cup) and meat (often deer), one slice oven bread, and two cups coffee with milk eaten at home with family.

Physical activity:

Sedentary, though increased activity.

Three days per week walking 15–20 minutes. She values increased energy and confidence level. Feeling less tired.

Short-term goals negotiated:

1. Goal not met. Feeling better now that the blood glucose values are not above 200 anymore. All FPG values over 130. Retain goal of ≥ 50% of blood glucose in FPG range of 90 130 and two hours after meal, less than 160 to be achieved through consistent carbohydrate intake budget of 120 g/day, medications, and daily short walks.
2. Weight loss of 1 2 pounds per week.

Long-term goals negotiated:

1. A1C ≤ 6.5%.
2. Weight loss of 10–14 pounds within six months, and weight loss maintenance for improved insulin response.
3. Blood pressure control ≤ 130/80.
4. LDL-C ≤ 70 mg/dl.

Instructions to patient:

1. Praise for diabetes self-management behaviors, especially reduced sugary drinks, smaller portions of bread, checking blood glucose again, walking, and taking medication as prescribed.
2. MNT: G.C. says she wants ideas on what else to eat for breakfast, either take-out food from the restaurant or what she can pack from home to eat. Ask G.C.

to identify foods she enjoys eating for breakfast. She states leftovers, breakfast burrito with egg, and potatoes. Using sample restaurant menu and meal plan handout, ask her to select a meal, and identify the foods with carbohydrates. Select a breakfast meal ≤ 45 g. Reinforce carbohydrate budget.

3. Review and discuss SMBG logbook. FPG: 159, 143, 173, 130, 152, 186, 145, 158, 140. Praise for reinitiating SMBG. Blood glucose values lower than the prior 200s she was experiencing, but still not at goal of over 50% of values at 90–130 pre-meal. Discuss post-meal goal of < 160.
4. Medication: Recommend patient increase the metformin as prescribed yesterday by physician, and continue lifestyle interventions (i.e., eating and exercise plan).
5. Physical activity: Issue a pedometer from the Tribal Diabetes Grant Program to her. Explain use and long-term goal of 10,000 steps per day. Negotiate goal: Walk everyday 15–20 minutes in the afternoon, and encourage more steps throughout the day. Monitor the number of steps for three days to figure out the beginning level. After a few days, increase by 1,000 steps per day for 1 2 weeks . G.C. says, "I'll ask my daughter to walk with me when I get home. We could get some steps in there."

Plan and evaluation:

1. MNT: G.C. agrees to follow two main meals and two snacks meal pattern with carbohydrate budget of 45:15:15:45 g. She plans to save money and carbohydrates by bringing breakfast burrito from home for her morning meal. She will note variations to carbohydrate budget in her SMBG logbook.
2. Physical activity: G.C. agrees to increase physical activity. She wears a pedometer and sees the stepcounter increase as she practices in the clinic hallway. She agrees to daily short walks of 15–20 minutes as breaks around the Santa Fe plaza, and suggests walks with her daughter after work of 10–15 minutes. She will write the number of steps per day in her SMBG logbook.
3. SMBG: G.C. agrees to check blood glucose every day, twice a day—one fasting and one reading two hours after a meal to see how the amount of food, exercise, and medicine is working to manage her diabetes. "Then I can see how much the exercise and foods lower or raise my blood sugar," she said. Request that she return with the record book for the next visit. Reinforce blood glucose goals. Advise that she will have her A1C measured at next visit; would expect 0.5 to 1.0 point lowering.
4. Medication: Encourage G.C. to take the increased dose of metformin in the evening (1,000 mg instead of 500 mg), and explain that this is still not the maximum effective dose. The increased metformin dose, as well as the lifestyle changes, should lower the morning fasting blood glucose.

5. Follow up: Schedule follow-up MNT and diabetes management for four weeks to evaluate goals.

Purpose of visit:

97803 MNT Medical Nutrition Therapy, Follow-up

Diabetes type 2 uncontrolled

Extreme obesity

Patient education:

DM – LA – G – 5 min – cb (Identify support people daughter and fellow jeweler on plaza for walks)

DM – MNT – G – 20 min – cb (Describe the effect of food on diabetes, portion sizes, and how timing and consistency of food can help people with diabetes target their blood sugar goals)

DM – EX – G – 5 min – cb (Discuss simple ways to measure exercise intensity)

DM – M – G – 5 min – cb (State the names of diabetes pills, how much to take, when to take them, how they work, and possible side effects)

DM – HM – G – 5 min – cb – GM (State or write a plan to change one or more behaviors – increase blood glucose measures to two per day)

(**Note from writing team**: To determine the MNT billing units, the billing staff will use the start time and end time of the patient face-to-face visit. In this case study, the start time is 9:00 a.m., and the end time is 9:45 a.m., for a total of 45 minutes [see page 44].)

Revisit:

4 weeks

Purpose:

Evaluate goals, behavior changes

Instructions to patient:

1. Reduce bread intake from two servings to one serving per meal. Choose healthier foods at restaurants. Take a healthy breakfast and snack to work a few days a week.

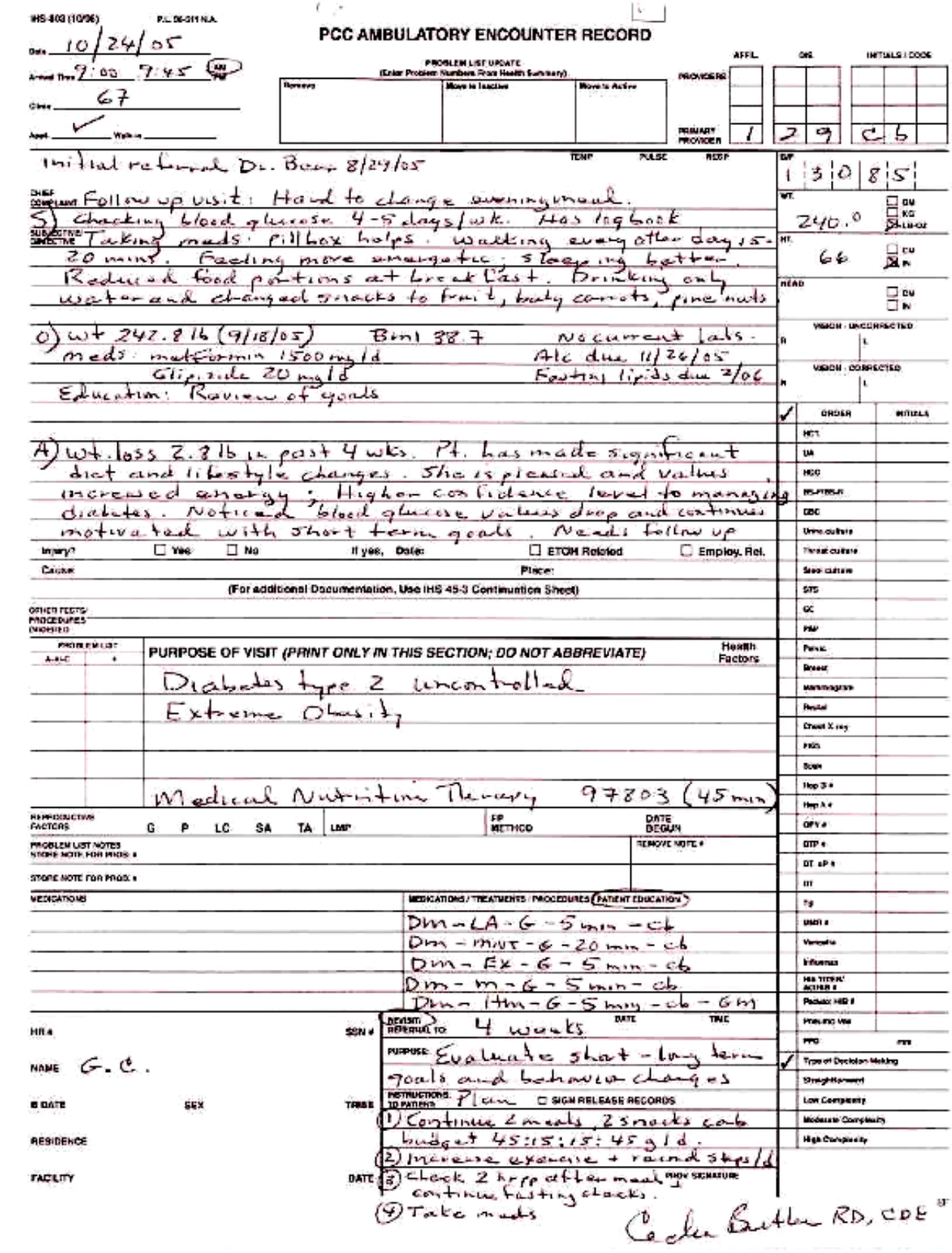
(Appendix B: Case Study Using Nutrition Practice Guidelines: **Follow-up Visit** – continued)

2. Continue walks around the plaza of two short walks (5–10 minutes)/day, 3 or more days/week. Increase if you have the energy, such as 10–15 minutes /day. Invite fellow jeweler and/or daughter to join her for walks for support.
3. Use pillbox, and take all medications (the larger dose of metformin) as prescribed.
4. Monitor fasting blood sugar and once after a meal (two hours post-meal), daily (preferable) or four days/week; write in logbook or return to clinic with meter (check memory feature).

Signature of Primary Provider: ***Cecilia Butler, RD, CDE***

Cecilia Butler, RD, CDE

Appendix B: Case Study Using Nutrition Practice Guidelines: **PCC Form for Follow-up Visit**



IHS-600 (10/96) P.L. 86-521 N.A.

PCC AMBULATORY ENCOUNTER RECORD

Date 10/24/05
Arrival Time 9:00 7:45 AM PM
Clinic 67
Appt ✓ Walk-in

PROBLEM LIST UPDATE (Enter Problem Numbers From Health Summary)
Remove | Move to Inactive | Move to Active

AFFIL. | ORG. | INITIALS / CODE
PROVIDERS
PRIMARY PROVIDER 1 | 2 9 | C 5

Initial referral Dr. Bean 8/24/05

TEMP PULSE RESP BP 130/85

CHIEF COMPLAINT Follow up visit: Hard to change evening snack.
S) Checking blood glucose 4-5 days/wk. Has log book
SUBJECTIVE/OBJECTIVE Taking meds: pillbox helps. Walking every other day 15-20 mins. Feeling more energetic: sleeping better. Reduced food portions at breakfast. Drinking only water and changed snacks to fruit, baby carrots, pine nuts

WT. 240.0 ☐ OU ☐ KG ☒ LBS-OZ
HT. 66 ☐ CM ☒ IN
HEAD ☐ CM ☐ IN
VISION - UNCORRECTED R L
VISION - CORRECTED R L

O) wt 247.8 lb (9/18/05) BMI 38.7 No current labs.
meds: metformin 1500 mg/d A1c due 11/26/05
Glipizide 20 mg/d Fasting lipids due 3/06
Education: Review of goals

A) Wt. loss 2.8 lb in past 4 wks. Pt. has made significant diet and lifestyle changes. She is pleased and values increased energy. Higher confidence level to managing diabetes. Noticed blood glucose values drop and continues motivated with short term goals. Needs follow up

Injury? ☐ Yes ☐ No If yes, Date: ☐ ETOH Related ☐ Employ. Rel.
Cause: Place:
(For additional Documentation, Use IHS 45-3 Continuation Sheet)

OTHER TESTS/PROCEDURES (ORDERED)

✓	ORDER	INITIALS
	HCT	
	UA	
	HCG	
	RS-STREP	
	CBC	
	Urine culture	
	Throat culture	
	Stool culture	
	STS	
	GC	
	PAP	
	Pelvic	
	Breast	
	Mammogram	
	Rectal	
	Chest X-ray	
	PSDS	
	Scan	
	Hep B #	
	Hep A #	
	OPV #	
	DTP #	
	DT aP #	
	DT	
	Td	
	MMR #	
	Varicella	
	Influenza	
	HIB TITER/ ACTIVE #	
	Pediatric HBV #	
	Pneumococcal	
	PPD mm	
✓	Type of Decision Making	
	Straightforward	
	Low Complexity	
	Moderate Complexity	
	High Complexity	

PROBLEM LIST: A=I/C, # | PURPOSE OF VISIT (PRINT ONLY IN THIS SECTION; DO NOT ABBREVIATE) | Health Factors

1. Diabetes type 2 uncontrolled
2. Extreme Obesity
3. Medical Nutrition Therapy 97803 (45 min)

REPRODUCTIVE FACTORS G P LC SA TA LMP FP METHOD DATE BEGUN
PROBLEM LIST NOTES STORE NOTE FOR PROB. # REMOVE NOTE #
STORE NOTE FOR PROB. #

MEDICATIONS | MEDICATIONS / TREATMENTS / PROCEDURES (PATIENT EDUCATION)

DM-LA-G-5 min-cb
DM-MNT-G-20 min-cb
DM-EX-G-5 min-cb
DM-M-G-5 min-cb
DM-Htn-G-5 min-cb-GM

HRN SSN #
NAME G.C.
DOB SEX
RESIDENCE
FACILITY

REVISIT/REFERRAL TO: 4 weeks DATE TIME
PURPOSE: Evaluate short-long term goals and behavior changes
INSTRUCTIONS TO PATIENT: Plan ☐ SIGN RELEASE RECORDS
(1) Continue 2 meals, 2 snacks carb budget 45:15:15:45 g/d.
(2) Increase exercise + raise steps/d
(3) Check 2 hrs after meals, continue fasting checks.
(4) Take meds
DATE PROV SIGNATURE Cecelia Bartlett RD, CDE